apy.[9] Further, ceftazidime monotherapy for infections of other body sites has led to the emergence of strains of *Pseudomonas* resistant to this drug.[10]

The present state of things has been ably summarized in Table 1 of the article by Ampel and Labadie. Other considerations pertain in Europe, where the primary therapeutic approach is often that of using cefotaxime as initial empiric therapy for all cases of meningitis before isolation and sensitivity testing of the organism.[11,12] A similar pattern of use was previously noted for cefuroxime in the same area. There is a problem in this form of therapy. None of the available cephalosporins are adequately active against *Listeria monocytogenes,* an infrequent meningeal pathogen in this country (although several recent dairy outbreaks may eventually challenge this generalization). In the dairy farm areas along Europe's northeastern coast, *L monocytogenes* is an important pathogen in neonates, pregnant women and immunosuppressed patients. We have asked several colleagues from that area what they do in this circumstance. Apparently for such high-risk groups, they just add amoxicillin to the cefotaxime regimen.

How can one explain this radical difference in patterns of antibiotic use? Our European colleagues make the following points: First, the limitations of the newer cephalosporins—that is, lack of effectiveness against *Listeria* and enterococci—are minor compared with the limitations of ampicillin (amoxicillin) or chloramphenicol. Second, the age-related separation of pathogens is hardly absolute. Adults can have *Salmonella* or *H influenzae,*[13] just as children can have pneumococcal meningitis.[12,14] Last, the ordinary diagnostic measures that we recommend in cases of meningitis are subject to error. A far higher percentage of cases than we would like to admit has negative Gram's stains or fails to produce positive cultures. Immunologic methods are most useful for *H influenzae* meningitis, but of little help for other forms of meningitis. Even when smears are positive, the correct diagnosis may not be made. Another reason for this difference in practice may lie in the nature of the clinical practice of pediatrics or infectious disease in large parts of Western Europe as compared with the United States. The separation of the hospital from office practice has progressed much further in Europe than it has in the United States. The hospital staff is full time, the hospitals are quite large and the infectious disease and pediatric specialists often have primary responsibility for 50 to 100 beds in the larger centers. In short, after the nth case of meningitis, what does one want with a complicated therapeutic schema? In this country few infectious disease specialists or pediatricians have primary clinical care responsibility for more than a few such cases each year. Hence, complicated schemas are possible. If my observations are correct, we should detect a future tendency toward a unitary initial therapy in the larger clinical centers in this country. Perhaps in a few years' time, Ampel and Labadie will again have to revise their therapy table, signifying an even greater change in antibiotic usage.

In summary, the past five to ten years have been a period of considerable change in our patterns of use of antibiotics for meningitis. Cephalosporins achieve significant antibiotic concentrations in the CSF of patients with meningitis, and several have sufficient activity to be of broad use in treating the four most common meningeal pathogens: pneumococci, *H influenzae,* meningococci and the enteric gram-negative rods. Chloramphenicol is now viewed as having a limited role and that only in treating bacteria for which it is bactericidal. Indeed, it is now conceded that to successfully treat meningitis (as to treat endocarditis) one must choose a bactericidal drug. Well, almost always! Those *Listeria* again! Neither ampicillin nor penicillin is reliably bactericidal for *L monocytogenes,* at least in the concentrations achievable in the CSF.[15,16] An aminoglycoside needs to be added to achieve that in the test tube. Yet, ampicillin and penicillin work even as monotherapy, and it is hard to show that adding an aminoglycoside clinically changes the response rate.[7]

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The Chief Complaint

IN PATIENT CARE the "chief complaint" gives the first indication of why a patient may be seeking a physician's help. Sometimes the chief complaint relates to the obvious. "I cut my finger." "I am allergic to cats but I love my cat." But sometimes the relationship between the chief complaint and what is really wrong may not be so direct or obvious. "I have a pain in my belly." "I have headaches all the time." "I have pains around my heart." And if one is privileged to take care of a physician or a nurse, the chief complaint and the description of symptoms (1) may be a model of professional accu-

racy, (2) may be a textbook description of something they believe they have but do not or (3) may have nothing to do with the real problem, all the pertinent information having been suppressed for one reason or another. In short, the chief complaint may be direct and to the point; it may be an important guidepost, opening the way to a correct diagnosis and treatment, or it may be a smokescreen hiding the real trouble and sometimes, though rarely, it may be actually misleading.

There appears to be a perception in today's society that there is something wrong with the medical profession. Somehow the profession is not what it used to be. We hear the complaints. "Health care costs too much." This comes mostly from those who have to pay the bills. In the same vein, the chief complaint of the public against the medical profession may well be that "doctors make too much money." Is this last complaint direct and to the point? After all, the average income of physicians in this nation is said to be in the neighborhood of $100,000 a year. Or might it be a point of departure that could open the way for a dialogue leading to a more complete diagnosis of the real concern? Or could it be a smokescreen hiding an unspoken but deeper dissatisfaction? One wonders whether it might not be all of the above.

But is the perception that physicians make too much money really all there is to the problem? One senses that it is not. Some physicians make a lot more and some make a lot less. And given the amount of training involved and the amount of responsibility entailed, annual earnings of $100,000 may not be all that far out of line. After all, this is about what commercial airline pilots are said to make. Perhaps it would be worthwhile to attempt to open a dialogue to try to reach a diagnosis—that is, to try to find more accurately what it is the public perceives to be wrong with the medical profession. After all, this is what physicians do in professional practice when they begin to evaluate someone's chief complaint in their offices.

The profession has substantial skills when it comes to discovering what it is that underlies a patient's chief complaint. These skills involve listening to what a patient has to say, taking a careful history, doing a careful hands-on examination, and actually measuring whatever can be measured that might help with the diagnosis or treatment. But it is noteworthy that all this occurs within the well-known framework of a doctor-patient relationship. The patient has a problem and the physician tries to find the cause and then attempts to do something about it. But there has to be a professional interaction between physician and patient—that is, the physician must be in the role of physician to the patient or the process will not occur and the cause of the chief complaint will not be found.

To return to the societal complaint that "doctors make too much money," one may ask where is the doctor-patient relationship between the medical profession and the society it serves? Where is the process for dialogue to try to discover the real reason for the complaint? It does not seem to exist. To enlarge upon this, could it be that society as a whole somehow senses that it has lost its physician and that this is really what is wrong, and therefore a fundamental cause of disaffection with the medical profession? Even if this is the case for society as a whole, it is worth noting that this may not be so true in smaller communities, where local physicians not only take care of patients in a very personal way but in the aggregate they actually serve as "physician" to the community by participating in community affairs, studying local health problems and giving needed and respected consultation and guidance to the community.

One can only wonder if a truly professional examination of the "chief complaint" we have selected—that is, "Doctors make too much money" or any other such complaint for that matter—might be used as a point of departure for some sort of a professional diagnostic process, adapting traditional diagnostic skills in such fashion so as to begin to understand what really underlies some of these societal complaints. The medical profession has the training to find a way to do this. It would only be necessary to develop a diagnostic approach that would in some way parallel what physicians do when they examine a patient's complaint in their everyday practice. If this were done successfully, the profession would have developed a new approach to better address some of the problems of health care in today's society. Organized medicine could then begin to play the role of physician to society, even while investigating complaints that might lead to the very realization that the profession should indeed play this role. It seems reasonable to believe that, just as in some smaller communities, the role of physician to society by organized medicine, on a local, state or national scale, could be powerfully effective, and in both the profession's and the public's interest.

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